

TRANSYLVANIA COMMUNITY HOSPITAL
BREVARD, NC 28712

INFORMATION REQUIRED FOR MEDICAL TREATMENT

CAMPER/STAFF INFORMATION

Name _____ Date of Birth _____
Address _____
Phone _____ Social Security _____

PARENT INFORMATION

Mother's Name _____ Social Security _____
Address _____ Home Phone () _____
Employer _____ Work Phone () _____
Employer's Address _____
Father's Name _____ Social Security _____
Address _____ Home Phone () _____
Employer _____ Work Phone () _____
Employer's Address _____

INSURANCE INFORMATION

Insurance Company Name _____
Address to mail claim _____
Phone # for benefits () _____ Group Name _____
Certificate or Policy # _____ Group # _____
Policyholder Name _____ Relationship to patient _____
Pre-Certification required? Y / N

■ ***Please attach a copy of your insurance card with this form***

EMERGENCY AUTHORIZATION

I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests and treatment for my child. In an emergency when I cannot be reached, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above.

SIGNATURE OF
PARENT/GUARDIAN _____ **DATE** _____